# GROUP ASO AND MINIMUM PREMIUM PLANS

*Moderator: RICHARD G. MURDOCK. Panelists: DAVID V. AXENE, WILLIAM CUNNINGHAM, RICHARD J. BARKSDALE**

MR. RICHARD G. MURDOCK: Group Insurance carriers are witnessing dramatic changes in their markets and products. Employers and other group policyholders are seeking alternative methods of financing their insurance -- with the ultimate goal of reducing costs. We have all heard of these arrangements, and many of us have worked closely with them. They range from the simplest adjustments to fully insured programs, such as a 90-day grace period, through concepts such as retrospective rating and cost-plus funding to schemes such as minimum premium plans, administrative services-only contracts and split-funding.

MR. RICHARD J. BARKSDALE: First of all, employees have been self-insuring a portion of all programs from the time that group insurance, as we know it today, began. In fact, in the very beginning, when only basic medical plans existed, employees were self-insuring their plans and now the only self-insurance by employees for their medical programs is through the deductible and co-insurance features of a group major medical plan.

Self-insurance has been permitted since 1928 under IRS Section 501; however, it was of limited use because accumulated investment earnings of trusts were not permitted to exceed 15% of the total trust balance. It was not until the 1969 Tax Reform Act that the real use of the 501(C)9 trust was established and for the first time, self-insured plans began to be looked at very strongly by many corporations. A survey conducted in 1974 of the Fortune 1,000 companies provides some insight into answering the question, who self-insures how for what?

OF COMPANIES PROVIDING EACH PLAN,
PERCENT FUNDING IT BY
SELF-INSURING
(WITH OR WITHOUT ASO)

| | TOP 500 | 2ND 500 |
|---|---|---|
| TEMPORARY DISABILITY | 42% | 37% |
| SURVIVOR INCOME | 17 | 16 |
| BASIC GROUP HEALTH | 13 | 14 |
| GROUP MAJOR MEDICAL | 12 | 12 |
| LONG-TERM DISABILITY | 8 | 6 |
| GROUP DENTAL | 6 | 18 |
| GROUP LIFE (TERM) | 3 | 4 |
| GROUP ACCIDENT (ALL RISK) | 1 | 4 |
| GROUP ACCIDENT (TRAVEL ONLY) | 1 | 2 |
| GROUP LIFE (WHOLE) | -- | 3 |

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As you might expect to see, the group accident is at the bottom of the list and temporary disability is at the top of the list. Of the top 500, 42% self-insure temporary disability, and 8% of the companies self-insure long-term disability. Of the 337 Fortune 500 firms who responded, 12% indicated that they were self-insured for major medical and 13% self-insured the basic medical.

There are a number of reasons why a company goes self-insured. However, it is seldom that these reasons are other than purely financial. There are the premium taxes which average 2.5%. There is a risk charge which is somewhere between nothing for some companies to 1% to 2.5%. Of course, commissions are not included and, on the average, this is approximately 2% to 3% but is not necessarily a cut in cost as the employer will probably assume like expenses.

In regard to administration, some employers like having the flexibility of plan design. Most employers feel that they can be more efficient than insurance companies. They may also be able to implement specific programs in claims control that are not in insured programs. Employers do not have to live with underwriting rules. They can also become involved in their own administrative systems. Employers do not have to become bogged down in premium administration systems designed by insurance companies which may not specifically fit a particular company.

There are some other reasons. I think the vast majority of employers who enter into self-insurance programs do so with their eyes wide open. However, there is a limited number of companies who enter into self-insurance since it's "in vogue" - it seems like the thing to do. I experienced an incident with a medium-size company in which I think you would be interested. In talking with a personnel manager recently, we were discussing job opportunities with a major corporation. I mentioned a Fortune 500 company. He responded, "Oh, they're sophisticated. They self-insure and everything!" - as if to say that an employer who self-insures was considered sophisticated.

We know of companies that have entered into self-insurance simply because they did not take steps to evaluate the many available cash-flow devices that could be more advisable than pure self-insurance. I am referring to split-funding plans, minimum premium plans, retros, etc. They have made the straight switch without evaluating whether they may have been able to reach their goals more effectively through these other cash-flow devices.

One of the things, of course, that self-insuring does do is eliminate renewals. Instead, rate actions occur daily. We think that this eliminates the annual problems surrounding major rate actions.

There are a number of reasons companies don't self-insure. One example which we have seen is a major contracting company whose work is on a cost plus basis. This company is a labor-intensive organization whose employee benefits costs are substantial. This company felt that it would cause problems for them to charge back to a specific job any direct-claim payments in a month where the claims had fluctuated adversely. They wanted a smoother line, more stable costs month after month, and they also wanted costs which were labor related. Adding a number of employees was expected to increase the cost; adverse claims were not.

Other reasons that companies don't self-insure include:

1. Possibility that self-insurance may be subject to state regulations.

2. Loss of protection against drastic claims fluctuation.

3. Loss of deductibility as business expense of claims reserves.

4. Possible loss of third party "buffer" on eligibility, claims and other questions.

5. Employer pays entire administrative cost of "non-insurance".

6. Possible increased employer expenses, as insurance companies normally increase their cost of administering a self-insured plan due to investment income loss.

7. Possible negative union reaction as benefits are not guaranteed.

8. Possible negative employee reaction to not having their plans insured.

9. Fear of the unknown.

The following are questions to address when considering Administrative Services Only. The answers may result in reasons not to self-insure.

I. Change-over from insured to ASO

   1. Which insurance company will perform this service?

   2. How will the change affect the other insured lines of coverage?

   3. How will reserves be released?

   4. What information and data requirements does the carrier require?

II. Accounting

   1. Will claims be paid by check or draft?

   2. What special banking arrangements need to be made?

   3. What liquid funds will be required and where will they be held?

   4. Will any special accounts be needed?

   5. Will a trust account be required?

   6. What will be the daily volume of transactions?

   7. Will any special cost accounting arrangements be necessary or desirable?

III. Audit

   1. What internal auditing facilities are available?

2. How extensive an audit of claim payments will be required?

3. Will the company's independent auditors become involved in the plan?

4. Would the independent auditors increase their fee because of the additional work involved in auditing the insurance accounts?

5. What asset and liability items would they expect to see on the balance sheet because of ASO?

6. What would they use to test the accuracy of such items?

7. Would they expect to test claim payments for accuracy?

8. How would they test the accuracy of payments?

IV. Communication

1. To what extent will the various outlying divisions become involved in the administration of ASO?

2. How will communication with outlying divisions be handled? Mail - how much? Telegraph - how much? Telephone - how much?

3. What outlying employees will be involved?

4. How will the corporation's insurance department explain to these employees what is expected of them in connection with administration and claim settlement, if any?

5. What priority will be assigned to carrying out benefit plan assignments by outlying employees or will the insurance company perform this service?

6. What demands will be made on stenographic service in the central office and in the outlying divisions?

V. Comptroller

1. Will any special arrangements need to be made with respect to the printing of special forms?

2. How much responsibility will the comptroller feel he has for cost control with respect to ASO?

VI. Legal

1. Will a formal written description of the benefits be necessary?

2. Who would draft the plan?

3. Who would advise as to legal liability under the plan in contested claim situations?

4. Is there any possibility of a suit against the company arising out of a claim?

5. How would such a suit be defended?

6. Who will draft the description of the plan to the employees, particularly if there is a change in benefits?

7. Who will decide what changes in the plan can safely be effected by administrative procedure and what changes will need to be incorporated in the written plan?

8. Who will decide whether the employees need to be given written notice of changes in the plan?

9. What is the tax status of employee contributions to the plan?

10. What is the tax status by state?

VII. Medical

1. Will the medical department be prepared to give assistance in connection with the settlement of difficult claims?

2. How many such claims will there be in a year's time?

3. Will the medical department be called upon to review evidence of insurability for late applicants?

4. How many such applicants will there be in a year's time?

VIII. Actuarial

1. Will the services of an actuary be required?

2. If so, to what extent and how much will it cost?

3. Who will decide what experience data will have to be maintained in order to make it possible for an actuary to calculate costs of revised plans?

4. Who will be responsible for maintaining data of this type?

5. Who will be held responsible for making cost estimates for each year and making experience reports to management?

IX. Management

1. Will it be necessary to develop administrative and claim manuals to assure uniformity of handling throughout the company?

2. How much will it cost to develop and maintain such manuals?

X. Employee Relations

1. Will the various unions become involved in the settlement of claims under an ASO plan to a greater extent than under an insured plan?

2. Who will have ultimate responsibility for deciding whether to pay a particular borderline claim?

3. Will employees be able to assign their benefits on the same basis as at present and what steps will have to be taken in order to make sure that hospitals and doctors will accept such assignments?

XI. Claim Statistics and Claim Settlement

1. What statistical data from the carrier will be necessary?

2. What statistical data will be shown only on the claim forms?

3. What claim payment summaries will be made and what part of the information shown on drafts will be punched into the cards used in making the claim payment summaries?

4. Who will be responsible for setting up the procedures for comparing actual claim payments with the statistical material assembled in connection with filed claims?

5. Who will determine what types of statistical information will be useful and how to apply the information in analyzing the costs under the plan and the probable cost under revised plan?

6. How will coordination of benefits be administered?

7. How will conversion be handled?

What are the trends? Taking our information from the Fortune survey, again, among the top 500, 45% have reported self-insuring an average of 1.7 of their insurance programs. In the second 500, 36% reported self-insuring an average of 2.1 programs.

About 33% of the companies expect the self-insured portion of their employee benefit insurance to increase in the next 3 years. Increases are expected by 44% of the companies which already self-insure and 29% of the companies which do not yet self-insure. ERISA's pre-emption of State control over self-insurance programs will be far-reaching.

The most important case is Monsanto vs. the Missouri Insurance Department which was overturned by the State Supreme Court. The case seemed to still the waters and ERISA's passage further supports self-insurance. ERISA Section 514 effectively supersedes state laws and exempts self-insurers from the risk of being considered in the insurance business. While there still remains some risk of regulation, this risk is minimal compared to the early 1970's. We would expect that more employers will now look towards self-insurance.

MR. BRENDON O'FARRELL**: I have seen a number of 100 to 500 life employers receiving one sided proposals to self-insure. The proposals promise 30 to 40% savings. Have you seen this?

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MR. BARKSDALE: I suppose this comes from agents selling one product. The employer needs to look at the long term effect and needs good information. We do not see many small employers moving to self-insurance.

MR. WILLIAM W. KEFFER: Are the difficulties in administering coordination of benefit provisions an argument for an insured plan? Is there strength in the argument that a third party administrator can arrange the plan so that it is second and not primary?

MR. BARKSDALE: Quality of claims control varies widely among insurance companies as well as among third party administrators. Third party administrators do use the arguments you described.

MR. WILLIAM CUNNINGHAM: Pacific Mutual is in the top 15 group companies with our business written predominately in the west. We have been a major writer of multiple employer trusts (MET) and our attitude towards ASO is influenced by the MET events of the past 2 to 3 years. Our MET success is due to Pacific Mutual retaining control of the accounts. We are concerned about the lack of control that many companies exercise and we believe that, for some of them, ASO's could lead to a repeat of the MET.

An employer is sold on ASO for 3 main reasons --- (1) premium tax savings, (2) higher yield or use of funds that are required for claim reserves and (3) flexibility of benefit design. It has been our experience that this latter point is not important and we have had no problem in requiring the employer to comply with statutory requirements.

As all of you know, an ASO requires unique handling --- starting with a special bank account, additional reporting and specialized people handling the account. These add up to higher, not lower administrative costs.

It may seem that I am negative to ASO. That is not the case. My concern is "does the client understand what he is buying". It has been my experience that no matter how explicit you are, often the answer is No!

Regardless whether a case is insured - conventional or minimum premium plans --- or self-funded, there are three basic functions that must be provided: a) risk assumption, b) cash flow management, and c) plan administration.

Traditionally these roles have been filled by the insurance industry on an insured basis. A question that I would like to raise, but for which there is no answer is: does the trend towards ASO and minimum premium plans mean a diminished role for the insurance industry or is it a natural evolution? Twenty years ago we saw an evolution occur in the pension field. Many changes occurred in industry practices and today the pension industry is very healthy.

A: Risk Assumption

With the exception of the administrative services contract, none of the many alternatives presented change the fact that the risk is borne by the insurance company. On ASO, the employer bears the risk, but does the employer understand the nature of the risk? I am not concerned about large employers who generally understand claim fluctuation, but I do express concern about the employer with less than 1,000 employees. Many of these employers have marginal cash flow and could be affected seriously

by adverse economic conditions. Stop loss is not the answer as it begins at a relatively high point (110% to 125% of expected claims) and will it be renewed or if renewed at what high level? Several self-funded multiple employer trusts learned a bitter lesson in 1976-77. All actuaries should be concerned over our responsibility and that of our companies on the ability of a self-funded employer to meet the claims of his employees. All we need is a substantial employer to go into bankruptcy leaving his employees' claims unpaid and we invite ERISA involvement in the A&H field.

B. Cash Flow Management

Cash flow management in an era of high interest rates is and should be of concern and must be met head on. ASO gives the employer control of cash flow, but there are minimum premium plans or use of deferred premium plans which give equal control of the cash flow, but without the employer having to assume the risk involved. There is one benefit where I believe ASO does have merit, and that is LTD. There is no way that the insurance industry, unless there is a casualty company involved, can do as good a job of cash flow management as a large self-funded LTD plan using a 501(c) 9 trust to establish reserves.

C. Plan Administration

What has occurred over the years has been a fractionalization of administrative services. For years there has been the third party administrator who has performed eligibility and claim payment services. Generally these were for Taft-Hartley or association trusts and they performed the work normally done by the employer. The recent explosion has been the competition for benefit field payments -- such giants as Systems Development Corporation and McDonald Douglas are developing general systems. Major employers with strong systems capabilities (Lockheed for example) have developed their own claims system. More recently large brokerage firms such as Fred. S. James and Frank B. Hall have established subsidiaries to pay claims.

We have also seen large brokerage firms establishing a section to evaluate self-funded cases. Should we therefore be surprised to see a large employer purchase claim administration from one system, his actuarial or underwriting advice from a consultant, plan design from a broker, and stop-loss or risk taking from an insurance company?

This fractionalization of services is bound to cost more unless the current charges of the provider have been unreasonable. The risk charge through stop-loss may likewise be higher on ASO, than on an insured approach.

Is all this good or bad? Here again there is no one answer and my concern is the quality of advice given to the buyer. We have too many in the field selling advice or services when they do not have qualifications. For example an ex-agent of our company with one employee bid on settling claims on a million dollar case. His bid was so low that fortunately it was thrown out. Then, what about the insurance company who, in order to sell life insurance, sells stop-loss? What is their responsibility when either the administrator or employer gets into difficulty? What is the insurance company's responsibility to the employees of a marginal employer of 150 to 200 employees who wants to go ASO? Do we say no? What is the responsibility of the actuary,

either insurance company or consultant, to the employees of such a firm? If ERISA required an actuarial certification on such a plan, would you be prepared to sign? The actuary's answer should be the same --- with or without ERISA requirement.

Finally, I would like to ask about the employer's responsibility.

1. On a non-insured plan has he considered the hidden costs within or outside his organization?

2. Under ERISA, will he properly disclose to his employees full details of the arrangements of his plan?

3. Will anticipated cash flow and increased earnings on reserves be realized?

4. Will reserves be established to fully guarantee benefits?

5. What problems are created when his plan does not meet all the requirements of the state insurance laws?

6. Is there a likelihood of states taxing employer claim payments?

7. What is the likelihood of punitive damages for mishandling a claim?

8. Will the third party exercise claims cost control or does he merely pay claims as submitted? What about COB?

9. Will the employer participate in cost containment, health planning and hospital rate review programs --- either voluntarily or at the legislative level?

As actuaries, we have a responsibility to make sure that this rapidly changing picture is an evolution and does not result in dissatisfaction by the employees against the entire industry. The result could be a form of national health insurance that we would not like.

MR. BENJAMIN R. WHITELEY: Are employers assuming legal liability (e.g. punitive and consequential damages) and are they aware of that risk? How does the insurance company protect itself against these liabilities?

MR. CUNNINGHAM: Pacific Mutual will not take the claim fiduciary role under an ASO agreement even though that role is taken under an insured plan.

MR. STANLEY L. OLDS: What happens if an employer goes bankrupt? What about claim reserves? What do accountants require?

MR. CUNNINGHAM: Pacific Mutual recommends that employers establish reserves. I don't know if they set up a liability on their own books.

MR. BARKSDALE: Normally the employer will set up the liability in their financial statements. The auditors require knowledge of the reserves.

MR. DAVID V. AXENE: A brief introduction to SAFECO Life Insurance Company should help fill in a few questions you might have regarding our company. We are a medium-sized life insurance company subsidiary of a larger property and

casualty corporation. Our agency force is predominately independent agents, our current life in force is about $8,000,000,000, our estimated 1978 annual premium will be over $100,000,000 and currently we do not operate in the State of New York as a life company. Our group operations have been predominantly involved with life, accidental death and dismemberment, and disability, both short-term and long-term. In the late '60's, we carefully entered the small employer insured medical market. Our philosophy at that time was to avoid traditional group medical, especially on larger groups. It was felt that the smaller employer, multiple employer trust market, with canned or packaged benefits predominantly medically underwritten, would be more controllable. Our current federal income tax position has encouraged us to market our group insurance plans on a net cost basis without dividends or experience rating refunds. Other companies are now marketing on a similar basis giving us tougher competition. We needed a way to capture a greater market share of the group life insurance business. One of our answers was a Stop Loss product, or as we call it, Excess Loss insurance. This product, if managed carefully, would attract group life insurance where we weren't previously able to penetrate, as we didn't offer the traditional larger group insured medical plans. Our thinking process started in the early '70's and reached its peak with the writing of our first Excess Loss in mid-1975. We have maintained our initial underwriting philosophy of writing the group life risks in our marketing of Excess Loss. Thus far, our product has been very successful, and in fact our life experience has been better under this line than when sold elsewhere. The product has resulted in many new cases that we wouldn't have been able to obtain otherwise and also it has preserved many existing cases which without Excess Loss would have changed carriers to obtain medical coverage. I would like to describe the products written under our Excess Loss plans. We write both Aggregate Excess Loss and Individual Excess Loss coverages.

The Aggregate Excess Loss provides protection to the employer for the overall sufficiency of his employee benefit plan (i.e., per group protection), while the Individual Excess product covers claims on a particular employee or family in excess of some predetermined deductible level such as $10,000 (i.e., per person protection).

There are some terms used in the Stop Loss marketplace that I will now briefly define:

1. Margin.

   The percentage above the expected claims level that the employer accepts as additional risk. The insurance company is responsible for claims in excess of this margin level.

2. Attachment Point.

   The dollar amount above which the insurance company is responsible for claims.

3. Fund Factors or Fund Deposits.

   The amounts to be deposited in the employer's fund during the policy period for each employee, dependent, etc., which accumulate to the attachment point level.

4. Lag Discount.

   The discount often applied in the first year to give the employer an additional cash flow advantage due because of claims lag.

When we were getting into the market, there were very few companies actively involved, so we basically designed our own policy. While filing our policy, we discovered that a number of states have classified this as casualty coverage and would not approve this as a group life insurance company policy. (Arizona, Arkansas, Florida, Maine, New York, Pennsylvania.) A few other states would not allow a contract covering self-fund coverage at all. (Georgia, Hawaii, Mississippi, Missouri, South Carolina, Vermont.) Fortunately, SAFECO is also a property and casualty company, thus we were able to file in some of the states as a property and casualty company. Our field force has told us that in some of the states that we do not write in, other companies are actively marketing their products and some of the ones that we do write in, other companies do not market at all.

As this is a relatively new product in its current form, there have been many approaches taken. For example, our policy allows the Individual Excess premiums paid in a policy year to count as claims against the Aggregate Excess Loss attachment point, while most other companies do not do this. We have an insurance policy with the employer, others have gone the reinsurance treaty route with its advantage of no state filing. One area that has been of some concern has been the conversion privilege. Most employers are more comfortable if the self-insured program includes such privilege, and for a small additional fee we will include the traditional group medical conversion.

We have also included, upon request, benefits not normally written by SAFECO Life on an insured basis, such as dental, vision, etc. Also, if desired, an employer could include short-term disability within his Aggregate Excess Loss Umbrella.

When initially getting into this market, very little data was available to us, and our initial rating philosophy was quite simple and possibly naive. It was initially felt that if the attachment point would be established accurately at a level such as 125% of claims, and assuming that our expected claims are very good estimates of future actual claims, any premium charge made less expenses would be profit to the company. That is, we didn't expect very many claims to ever exceed the attachment point. This eventually propagated the philosophy that a $2,000 Aggregate Excess Loss premium would be adequate for most cases. This had been marketed for a period of time before we could make a more thorough analysis of our past experience and the actual risk to which the company was being subjected. Our current rating techniques, which have been used since 1976, were developed together with the help of a local consulting firm using a rather elaborate set of data showing anticipated claims levels for various-sized groups. With this, we could determine more accurately the charge required for the risk not taken by the self-insured employer. The factors taken into account include the plan of benefits, expected level of claims, the number of lives, the margin level (i.e., the excess risk assumed by the employer), etc. Typically, premiums range from about $1,500 to $10,000, depending upon the above factors. A key in the rate development is to develop a proper security loading, usually a function of the standard deviation of claims in excess of the level of the attachment point. These security loadings at the higher margin levels can significantly

exceed the expected claims level of the Aggregate Excess Loss premium. In addition, as a rather low premium is being charged for a substantial risk compared to the level of premiums of a fully insured plan, expenses can become a much greater part of the premium than you might initially expect.

A factor we have recently incorporated into our rating basis helps to load for fluctuations other than statistical fluctuations. Predictions of expected claims can vary from the actual claims because of the lack of credibility of the group, lack of underwriter expertise, characteristics of the group that are not reflected in the manual rating basis, changes in assumptions such as the level of inflation, plain errors, or others. We refer to this fluctuation as an uncertainty. We are more comfortable with our rating basis having accounted for this uncertainty.

Typical compensation levels for Aggregate Excess Loss run about 10% of the Excess Loss premium. Many producers accept no commission on the Aggregate Excess Loss coverage, but do receive a commission or fee from other coverages or services provided.

One very important area is who will process claims and do the other administrative functions that the traditional medical insurer did. Many companies have set up service companies to administer the business, and some administer it themselves, but others have chosen to use independent third party administrators. We have chosen the third party administrator route and realizing the vulnerability of this position, have attempted to establish controls to avoid problems other insurance companies have had with third party administrators. Some of our controls include:

1. Approval procedures for appointing third party administrators.

2. Establishment of an audit department to specifically perform routine audits of third party administrators.

3. Production requirements for a third party administrator to reach in order to maintain his appointment as an approved administrator.

We have been involved in many facets of Excess Loss. Some of the ideas we have experimented with are:

1. Partial Stop Loss.

   Partial Stop Loss is essentially a lower deductible Excess Loss program designed for the employer who either questions or is unsure of the self-funding concept. In this plan, he self-insures the first few thousand dollars of the plan and coordinates the balance with a fully insured higher deductible major medical plan.

2. Split Stop Loss.

   In this product the employer self-insures only certain benefits within his employee benefit plan. Certain industries may have had bad experience on certain benefits or coverages, or could select against you within such coverages; we encourage the self-insurance of these questionable coverages.

3. Small Group Excess Loss.

   The marketplace for small group Excess Loss is relatively untouched. Several programs are emerging for the 25 to 200 life range groups, but many companies still do not solicit business for the small groups.

Even though this product is doing quite well, and our production volume is high, there are areas of concern and problems. These include:

1. The effect of inflation at the higher deductible level.

   A 12% inflation rate on first dollar medical benefits multiplies into a 60% to 100% inflation rate at some extremely high deductibles. The renewal of such business on a case with low or no claims, with renewal rates increasing 100% because of inflation, becomes a rather difficult task, especially with eager competition. We have the philosophy that this coverage is not credible, and is similar to casualty insurance.

2. First Year Lag Discount.

   Many companies discount the funding factors in the first year due to the claims lag and extensions from the previously insured plan. If the funding factors are discounted, there is an automatic increase in the second year even assuming no inflation. There are philosophic differences here, as some feel that the employer should fund for the full incurred claims level and build his own incurred but unreported claim reserve, while others say that the employer needs the current cash flow advantages of discounted first year factors. I'd like to draw a comparison to pension funding in that the more conservative the plan funding, the greater the chance of meeting plan benefits.

3. Paid vs. Incurred Basis.

   We sell a claim paid product where we are covering losses for claims paid during the policy year. Therefore, to incur an Aggregate Excess Loss claim, the actual claims paid must exceed the attachment point by policy year-end. One area of abuse is that a third party administrator could arbitrarily slow claim payments at the end of a policy year to avoid a claim in one year, resulting with higher than expected claims levels in early months of subsequent years. We are currently establishing controls to avoid this problem or at least to be aware of changes in claims patterns that could affect renewal calculations.

4. Competition.

   A number of companies are entering this market, and are entering at what appears to be a rather low rate level. We have some concerns about this. Inappropriate rating and the resultant rate increases for such action, could lead to the erosion of confidence in this concept. We have learned during our three years of actively marketing this product that it is very complex, much more so than some

other products. We encourage companies entering this business to spend the required money to get good data, if not available in-house. The data is now widely available from many consultants or reinsurance companies.

5. Reinsurance.

Reinsurance is available for the carrier interested in pursuing the market on a trial basis, without retaining the entire risk. It is also available for the smaller carrier who may prefer to reinsure the entire block of business on a long-term basis. We have received several requests to become a reinsurer for companies entering this market, but have chosen to go only on a direct basis.

6. Third Party Administrators.

It is important to maintain control of third party administrators. We have established controls, audit procedures and audit teams to monitor these third party administrators. One word of caution is that there are many good third party administators, but there are also many that you should avoid. Don't assume that all offices of a nationwide administrator's offices are of the same competency level. We have found that each office needs to be underwritten as a third party administrator prior to their approval. Our current position is to continue use of third party administrators on a controlled basis.

7. Manual Rates.

One area we are now addressing is the time-consuming manual rate calculation needed to compare previous experience to manual rates, or the calculation of rates when no experience is available. Our current staffing does not include raters but we have even considered using these. We also have been considering the automation of calculation using our in-house mini-computer.

8. ERISA.

The same legislation that opened the door to Excess Loss, has also limited its use. Our group attorney tells us that ERISA will not allow a named fiduciary to receive a commission for the sale of insurance to an employee benefit plan. A producer who performs certain administrative services may be considered a fiduciary or party in interest and as a result must disclose commissions received. Insurance companies have varied opinions on ERISA and commission disclosure, but each company should establish its philosophy, especially in the Excess Loss market.

9. Marketing.

The key to marketing this product is to sell the concept, not necessarily the price. Once an enlightened employer sees that he can save money based on his group's experience, you have a good client for Excess Loss. An employer who is having the rate comparison hassles with the old insured plan is not a good Excess Loss prospect. We have discovered that very few self-funding employers

ever return to the insured medical program again. Now there is a strong competitive situation to keep business already on the books as Excess Loss with the increased number of carriers who are now in the market. A few words of suggestion are in order.

Be sure of the rate levels and be careful of what risks the replacement carrier is picking up. Often the new carrier could be picking up many claims previously incurred but not paid. We have run into several carriers who, hopefully, unconsciously are discounting fund factors in their first year of coverage, within a renewal year of self-insurance.

10. Reserves and Liabilities.

We have been trying to develop a good reserve and liability procedure for Excess Loss. For Aggregate Excess Loss we hold a formula reserve and liability similar to that we are currently using on our other medical products. I think that this is one area where our casualty friend should be able to educate us, as this product closely resembles some of theirs.

In summary, as we have made either direct or indirect references to ASO's, I thought I would relate Excess Loss to ASO's in a few particular areas:

| Item | ASO | EXCESS LOSS |
|---|---|---|
| Employer risk | Unlimited | Fixed per person and/or per group |
| Premium tax | None | On Excess Loss premiums |
| Administration | By insurer | Third party administrator/service subsidiary/insurance company |
| Profit sources | Cash flow, expense margin, investment income | Excess of premiums over claims and expenses |
| Insurer income | Administration fees, claims deposits | Premiums |

In conclusion, Excess Loss has been a good alternative to fully insured medical plans for SAFECO Life Insurance Company, although not without its problems. We have experimented with many varieties of this product and hope to continue our profitable marketing of this product.

MR. WALTER B. LOWRIE: Do you have limits on the amount of stop loss you will pay on any one case? A total limit on an aggregate basis?

MR. AXENE: No.

MR. LOWRIE: Doesn't that leave you open to high fluctuations?

MR. AXENE: That's true, but our individual excess will pick up fluctuations from high individual claims so you are really talking about an increase frequency problem, not necessarily a high amount problem.

MR. LOWRIE: How do you establish reserves?

MR. AXENE: Basically we monitor the case's loss ratio through the year. If claims ever exceed expected, we establish reserves based on projected loss.

MR. LOWRIE: Can you do it on a pooled basis?

MR. AXENE: We are growing too fast to use that approach.

MR. BARKSDALE: What is your total excess loss premium?

MR. AXENE: We have between one and two million dollars of individual excess and on the aggregate excess we have between 500 and 600 cases with annual premiums between $1,500 and $10,000.